OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Duexis® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Osteoarthritis and to decrease risk of developing upper gastrointestinal ulcers
❑ Rheumatoid arthritis and to decrease risk of developing upper gastrointestinal ulcers
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Arthrotec 50
❑ Arthrotec 75
❑ Famotidine and Ibu (individual agents used in combination)
❑ Famotidine and Ibuprofen (individual agents used in combination)
❑ Pepcid and Ibu (individual agents used in combination)
❑ Pepcid and Ibuprofen (individual agents used in combination)

Has the patient had a history of failure to cimetidine, famotidine, nizatidine, or ranitidine **AND** one oral generic non-steroidal anti-inflammatory drug (NSAID) (e.g., celecoxib, diclofenac potassium, diclofenac sodium delayed-release (DR), diclofenac sodium extended-release (ER), diflunisal, etodolac, etodolac ER, fenoprofen, flurbiprofen, ibuprofen, indomethacin, ketoprofen, ketoprofen ER, ketorolac, meclofenamate, mefenamic acid, meloxicam, nabumetone, naproxen, naproxen DR, naproxen sodium, oxaprozin, piroxicam, sulindac, tolmetin)? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading-dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____
❑ Other: _____

Duexis® Prior Authorization Request Form (Page 2 of 2)

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.